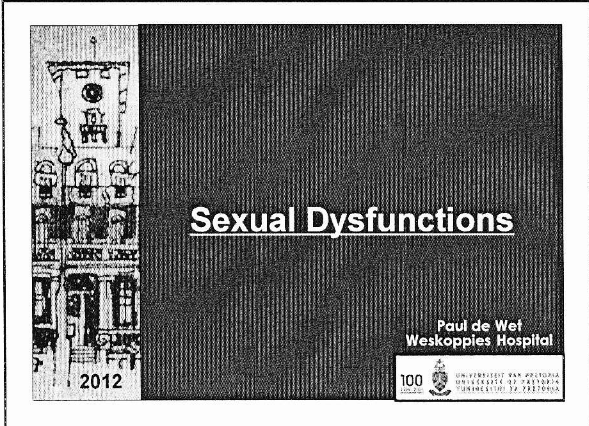
HANDOUT

2012/04/26



Structure:

1. General / Recap
2. Definition / 'Defining criteria'
3. Classified Categories
4. Disturbances SRC
5. Pain
6. ...'due to general medical condition'
7. Substance-induced
8. Not-otherwise-Specified
9. Treatment of SD

'An estimated 50% and more relationships / marriages are severely impaired by one or the other sexually related problem or maladaption....'

NORMAL HUMAN SEXUALITY

SEXUAL DYSFUNCTIONS

GENDER IDENTITY DISORDERS
PARAPHILIAS

'SD is a part of the greater concept of Sexual Disorders'

GENERAL:

- Essential part of curriculum
- An essential part of a general examination
- Acquire some comfort on the topic with your patients – do not shy away from the topic
- Sensitivity, method of approach, structured management
- Integrate meaningful, medically appropriate information
- Many patients do not complain – they need to be asked!

Definition / 'Defining criteria':

'....characterized by a disturbance in the processes that characterize the (psycho-) sexual response cycle or by pain associated with sexual intercourse...'

- Disturbance in sexual desire
- Disturbance in the psycho-physiological changes that characterises the response cycle
- Causes marked distress
- Causes interpersonal difficulty

CLASSIFIED CATEGORIES:

(Psychogenic etiology & Organic etiology)

A	DISTURBANCES IN THE PROCESSES THAT CHARACTERISE THE SEXUAL RESPONSE CYCLE
B	PAIN ASSOCIATED WITH SEXUAL INTERCOURSE
C	SEXUAL DYSFUNCTION DUE TO A GENERAL MEDICAL CONDITION
D	SUBSTANCE-INDUCED SEXUAL DYSFUNCTION
E	SEXUAL DYSFUNCTION NOT-OTHERWISE-SPECIFIED

A. DISTURBANCES IN THE PROCESSES THAT CHARACTERISE THE SEXUAL RESPONSE CYCLE

DESIRE	Hypoactive Sexual Desire Disorder		Sexual Aversion Disorder
AROUSAL	Female Sexual Arousal Disorder		Male Erectile Disorder
ORGASM	Female Orgasmic Disorder	Male Orgasmic Disorder	Premature Ejaculation
RESOLUTION	Post-coital Headache		Post-coital Dysphoria

Desire (Begeerte / Lus) Phase

(Emotional intensity with which one avoids sex)

Hypoactive Sexual Desire Disorder

↓ fantasies / desire

- 'Sex just isn't what it used to be...'
- Common – 20%
- Single / Mask other SD
- Circumstantial – work/stress
- Biological
- Substances
- Psychiatric = major role
- Interpersonal – difference between parners appitite
- Unattractive partner – change in the course of relationships
- SD?? / Satisfaction??

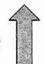
Sexual Aversion Disorder

(Aversion to / Avoidance of)

- "phobic", "loathing", "detesting" quality
- Traumatic event/s – rape, sexual abuse, - assault
- Extreme shyness
- Guilt feelings

Incidence may be very high in our society considering high rates of rape, abuse, AIDS, traumatic events

Excitement /Arousal Phase



Female Sexual Arousal Disorder

'persistent or recurrent inability to attain or maintain....an adequate lubrication-swelling response....'

- ? Revised to focus on subjective experience
- Often orgasmic problems as well
- Often associated with conflict

Male Erectile Disorder

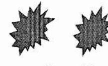
(Discussed)

Erection 'hardness':

- Graded 1- to an optimum 4
- Second to maintaining an erection

NB Depression + ED

Can indicate coronary artery disease



Orgasmic Phase

Female Orgasmic Disorder

'...delay or absence of ...following a normal excitement phase...'

- Anorgasmia is found in less than 5% / 24-30% orgasmic problems
- Wide variaty in type or intensity of stimulation that triggers orgasm
- > young women / ↑ experience / less psychological inhibition – *'sexual pleasure is not a natural entitlement for so called decent women'*

Male Orgasmic Disorder

'...delay or absence of ...following a normal excitement phase...'

- Not commonly found – 3,5%
- Many forms
- Interpersonal conflict
- OCD
- Guilt / Hostility
- Maturbation pattern
- Rigid puritanical background

Premature Ejaculation

'..onset of orgasm and ejaculation with minimal stimulation ....before the person wishes it...'

All definitions acknowledge 3 components:

- Short ejaculatory latency

- Lack of control over ejaculation

- Lack of sexual satisfaction (negative personal consequences)

- *Underestimated 10-80% (26% in Premature Ejaculation Prevalence Attitude survey)*
- *? = a condition where psychologically mediated process exacerbates an underlying organic component (penile hypersensitivity, hyper-excitable ejaculatory reflex, shorter nerve latency time, 5-HT receptor dysfunction (Hyposensitivity 5-HT$_{2c}$ (delays ejaculation) Hypersensitivity 5-HT$_{1a}$ (facilitate ejaculation))*

- *Anxious persons*
- *Age*
- *Professional persons*
- *Circumstances*

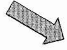
Differentiate PE & ED – PE may proceed or be secondary to ED (25-30% co-morbidity)

Screening instruments (PEP (PE Profile) PEDT (PE Diagnostic Tool) IPE (Index of PE)

Negative personal consequences:

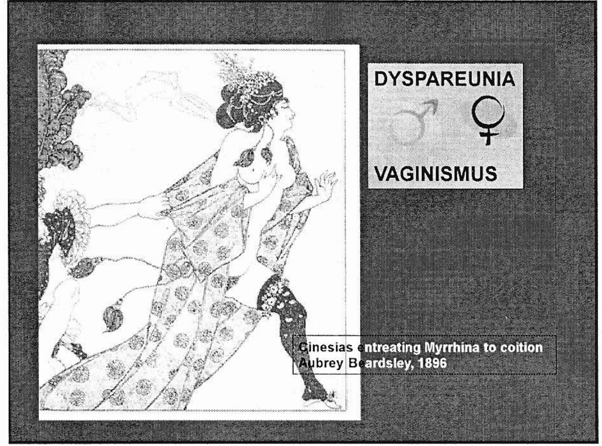
- *Distress*
- *Bother*
- *Frustration*
- *Avoidance sexual intimacy*

Resolution Phase



The phase is generally experienced by a sense of well-being and muscle and psychological relaxation:

- **To feel depressed, anxious, irritated, even agitated or become abusive or try to run away**
  - ?? How often this takes place – commonly seen in adultery, contact with prostitutes
  - ? Attitude towards sex
  - Fear of contracting HIV
- **? Incidence and cause of post coital headaches**



Ginesias entreating Myrrhina to coition
Aubrey Beardsley, 1896

Painful Ejaculation (Post-orgasmic Pain)

•Serious problem

•Radical prostatectomy, ejaculatory duct stones, pudendal neuropathy, anti-depressant medication,

'Although SDs are often related and symptomatic of intrapsychic or interpersonal problems; adversely affected by stress or emotional problems or ignorance....

AS MEDICAL PROFESSIONALS WE HAVE TO CONSIDER...':

1. MEDICAL CONDITIONS CAUSALLY LINKED TO THE SD
2. WAYS IN WHICH DRUGS, SUBSTANCES, MEDICATION CAN AFFECT SEXUAL FUNCTION

Evidence from the history, physical examination or laboratory findings that the SD is <u>FULLY EXPLAINED</u> BY THE DIRECT PHYSIOLOGICAL EFFECTS OF THE MEDICAL CONDITION.

- Neurological (MS, neuropathy, temporal lobe lesions..)
- Endocrine (DM, Hypothyroidism, hyperprolatinemia...)
- Renal / Urological (testicular disease, prostatectomy complications ...)
- Infections / Parasitic Diseases (vaginitis, urethritis...)
- Traumatic
- Hepatic / Pulmonary / Genetics / Surgical Procedures / Nutritional +++++++++++....

Examples:

- Hypoactive Sexual Desire Disorder <u>due to</u> decreased s-testosterone levels / Major Depressive Disorder....
- Female Sexual Arousal Disorder <u>due to</u> post-menopausal physiological status......
- Male Erectile Dysfunction <u>due to</u> post prostatectomy complications......
- Female Orgasmic Disorder <u>due to</u> Hypothyroidism....
- Male Orgasmic Disorder <u>due to</u> Parkinson's Disease......

Evidence from the history, physical examination or laboratory findings that the SD is <u>FULLY EXPLAINED</u> BY SUBSTANCE / MEDICATION USE.

Drugs Associated with SDs:

- Antiandrogens
- Antiarrhythmics
- Anticancer Agents
- Anticholonergics
- Antihistamines
- Antihypertensive
- Diuretics
- Hormones – Corticosteroids / Progestin
- Psychotropics
  - Antianxiety,
  - Anticonvulsants,
  - Antidepressants,
  - Antipsychotics,
  - Sedatives,
  - Stimulants

Illicit and non-prescribed drugs

- Alcohol
- Amphetamines
- Cocaine
- Heroin
- Marijuana
- Nicotine
- Opiates

Substances can have a DIRECT or INDIRECT cause for SDs:

Medication / substances side-effects can directly (chemical mechanisms) influence any aspect of sexual function	Indirectly – from some other drug effect influence sexual function
• Most cases desire • Erectile / Orgasm • Hypogonadism • Lactation	• Weight gain • Halitosis • Nausea • Dizziness / Sedation...

Examples:

- Alcohol-Induced SD, with Impaired Arousal
- Fluoxetine-Induced SD, with Impaired Orgasm
- Thioridazine-Induced SD, with Painful Orgasm
- Steroid-Induced SD, with Impaired Desire
- Antihypertensive-Induced SD, with Orgasmic Disorder

Important clinical considerations SUBTYPES

- SDs may occur in one OR MORE phases
- Clinical judgement about SDs should TAKE IN ACCOUNT
  age, experience, frequency and chronicity of the symptom (Lifelong / Aquired), subjective distress, effect on other areas of functioning, persistency, reoccurrences, focus and intensity and duration of stimulation, combinations of causes
- **Do not attempt to:**
  -Specify a minimum frequency
  -Specify range of settings or activities
  -Specify types of sexual encounters.....
  ....in which the dysfunctions must occur.

Previous factors must clinically be accounted for